CENTERSTON	WIEDICINE & WEDIC	THE SERVICES				•	10110107000071
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLE			LETED	
		155354	A. BUILDING 06/22/201			.011	
			B. WING				
NAME OF P	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE		
				l	POLLACK AVE		
NEWBUF	RGH HEALTH CAR	lE .		NEWBL	JRGH, IN47630		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG			DATE
	TEGGE TIGHT OF		+	1.10			5.112
K0000							
			17.0		Drangration and or evecution	o of	
	A Life Safety C	ode Recertification	Ku	0000	Preparation and or execution this plan of correction in gen		
	and State Licer	nsure Survey was			or any other action set forth	Ciai	
	conducted by t	the Indiana State			herein, in particular, does not	t	
	Department of				constitute an admission by	•	
	=				Newburgh Healthcare of the	facts	
	accordance wit	th 42 CFR 483.70(a).			alleged or the conclusions so		
					forth in the Statement of	•	
	Survey Date: 0	06/22/11			Deficiencies. The pan of		
	-				Correction and specific corre	ective	
	Facility Numbe	or: 000245			actions are prepared and or		
	•			executed solely because of			
	Provider Numb	per: 155354			provisions of federal and State		
	AIM Number:	100290800			laws.		
	Surveyor: Lev	Brashear, Life Safety					
	=	•					
	Code Specialis	t					
	At this Life Saf	ety Code survey,					
		Ilth Care was found					
	_						
	not in complia						
	-	for Participation in					
	Medicare/Med	icaid, 42 CFR					
	Subpart 483.7	0(a), Life Safety					
		the 2000 edition of					
	the National Fire Protection						
	Association (N	FPA) 101, Life Safety					
	Code (LSC), Ch	apter 19, Existing					
	Health Care Occupancies and 410						
	IAC 16.2.						
	IAC 10.2.						
	This one story	facility was					
	determined to	be of Type V (000)					
	construction a	• •					
	construction d	nu was luny					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CNVQ21

Facility ID:

000245

TITLE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155354			(X2) MULT A. BUILDII B. WING		O1	(X3) DATE S COMPL 06/22/20	ETED	
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN47630					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EAC)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	alarm system we detection in the spaces open to facility has a call had a census of this survey. Quality Review by I	e corridors and the corridors. The spacity of 114 and f 110 at the time of Robert Booher, REHS, Life ist-Medical Surveyor on						
compliance with the aforementioned regulatory requirements as evidenced by the following:								
K0029 SS=E	fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro When the approve extinguishing syste are separated from resisting partitions self-closing and no protective plates the	d construction (with 3/4 hour r an approved automatic fire em in accordance with 8.4.1 otects hazardous areas. In other spaces by smoke and doors. Doors are on-rated or field-applied that do not exceed 48 inches of the door are permitted.						
	Based on obser interview, the f ensure 1 of 18 room doors, su		K002	29	I. Corrective ActionAll hazard room doors will be equipped self-closing devices.II.Others Having the Potential to be affected.All residents III. Responsibility for ComplianceAdministrator and	with	07/22/2011	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DITT	DINC	01	COMPL	ETED
		155354		A. BUILDING B. WING		06/22/2011	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF PROVIDER OR SUPPLIER					POLLACK AVE		
NEWBUF	RGH HEALTH CAR	E			JRGH, IN47630		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	amount of com	ibustible material,			Maintenance DepartmentIV. Completion Date: 7-22-11		
	was equipped v	with a self closing			Completion Date. 7-22-11		
	device on the o	loor. This deficient					
	practice could	affect 24 of the 47					
	residents, as w	ell as staff and					
	visitors in the v	west hall.					
	Findings includ	le·					
	l manigs merae						
	Based on obse	rvation on					
		1:50 a.m. during a					
	tour of the faci						
		· ·					
	Maintenance Si						
		room in the west					
		fty square feet in					
	size and full of	combustible					
	material such a	as a large amount of					
	paper napkins,	toilet paper, and a					
	barrel full of us	sed mop heads.					
	The door to thi	is room was not					
	provided with a	a self closing					
	device. This w	as acknowledged by					
		ce Supervisor at the					
	time of observa						
	3.1-19(b)						
170050	A fine elements such a	m required for life sefety is					
K0052 SS=F	installed, tested, a	m required for life safety is and maintained in					
00-1		NFPA 70 National Electrical					
	Code and NFPA 7	2. The system has an					
		ance and testing program					
		plicable requirements of					
	NFPA 70 and 72.	9.0.1.4					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATI		(X3) DATE	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155354	B. WING 06/22/2011				
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				10466 F	POLLACK AVE		
	RGH HEALTH CAR				JRGH, IN47630		
(X4) ID		STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	17.0	TAG	I Corrective Action: Alarm		DATE
	Based on recor		K0052		system was checked by the	alarm	06/23/2011
	interview, the f				company on 6-23-2011. (54	ring All	
	ensure all fire a				alarms tested)II. Others hav		
	components ar	nd devices such as			the potential To be affected:		
	smoke detecto	rs were tested at			residents have the potential tagget affected by the		
	least annually f	for 1 of 1 fire alarm			practice.III.Measures and		
	systems, and t	he facility failed to			Systemic Changes:Maintena	nce	
	ensure docume	entation for the			and the Alarm Company will		
	testing of all si	noke detectors was			monitor for future compliance		
	correct. LSC 9.6 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm				Completion Date: 06-23-201	11	
		such as smoke					
	detectors, fire						
	· ·	evices, door holder					
		re alarm control					
		tested annually.					
		oractice could affect					
	·						
		s well as staff and					
	visitors.						
	Findings include:						
	Based on review	w of the facility's					
	quarterly fire a						
	inspection reports in the Inspections folder on 06/22/11 at 10:15 a.m. with the Maintenance Supervisor present, fire alarm system inspection reports dated						
	l '	•					
	07/21/10, 10/						
		not include visual					
	and functional	testing with a pass					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155354				ULTIPLE CO LDING	NSTRUCTION 01	(X3) DATE S COMPL 06/22/2	ETED
		100004	B. WIN			00/22/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE POLLACK AVE		
NEWBURGH HEALTH CARE				1	JRGH, IN47630		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE (DATE
		r fifty four of fifty ectors. The most					
	•	y fire alarm system					
	-	ort where all smoke					
		tested visually and					
	-	well as tested for					
	=	dated 04/13/10.					
	This was confir Maintenance Su	•					
		•					
	placing a phone call to the fire alarm inspection company to verify the company failed to						
	-	cheduled quarterly					
	inspection in A	•					
	Furthermore, th						
	inspection repo						
	07/21/10, 10/						
	01/11/11 all in						
	cover page the						
	•	orty seven total					
		rs (thirty nine Photo					
	,,	lon type), however,					
	the 04/13/10 s	-					
	-	d the facility was					
	provided with fifty four total						
		rs (forty six Photo					
		lon type). This was					
	_	by the Maintenance					
	-	ne time of record					
	review.						
	3-1.19(b)						
) J-1.19(D)						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPLETED	
		155354	B. WIN			06/22/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				10466 F	POLLACK AVE		
	RGH HEALTH CARE	=		NEWBU	JRGH, IN47630		
(X4) ID		Y STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per						
33-1	month in accordan	•					
	3.4.4.1.						
	Based on obser	Based on observation and)144	I. Corrective Action: Remote	Stop	07/22/2011
	interview, the f	acility failed to			Switch will be installed by EVAPAR by 7-22-2011.II. Other	ners	
	ensure 1 of 1 e	mergency			Having The Potential to be		
	generators was equipped with a				Affected by this Practice:All		
	remote manual stop. LSC 7.9.2.3			residents have the potential to			
	requires emerg	equires emergency generators			affected by this practice.III. Measures and Systemic		
	providing power to emergency lighting systems shall be installed,				Changes: Install Remote Sto		
					Switch.IV. Monitorted by		
		ested and maintained in			Administrator and Maintenance		
	accordance wit	h NFPA 110,			SupervisorV. Completion Date: 07-22-2011		
	Standard for En				07-22-2011		
		Systems. NFPA					
	110, 1999 edit	=					
		I installations shall					
	•	manual stop station					
		r to a break-glass					
		elsewhere on the					
		e the prime mover					
	-	de the building.					
	NFPA 37, Stand	_					
		Use of Stationary					
	Combustion En	•					
	Turbines, 1998 Edition, at 8–2.2(c) requires engines of 100 horsepower or more have						
		nutting down the					
	-	ngine and from a					
	_	-					
		n. This deficient					
		affect all occupants					
	in the facility.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155354			(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPI	COMPLETED 06/22/2011		
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN47630					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE		
	Findings includ	le:						
	equipment on op.m. during a twith the Mainte evidence of a redevice was not generator, furtiobservation of Maintenance Suthe generator was 2005. Finally, at the time of comparison of the generator was at the time of comparison of the generator was at the time of comparison of the generator was at the time of comparison of the generator was at the time of comparison of the generator was at the time of comparison of the generator was at the time of comparison of the generator was at the time of the generator was at the time of the generator was at the time of the generator was at the generator was at the time of the generator was at the time of the generator was at the gener	found for the hermore, during the generator the upervisor indicated vas installed in based on interview observation, the upervisor indicated emote shut off						